



STATE OF MICHIGAN
DEPARTMENT OF EDUCATION
LANSING

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**FISCAL YEAR 2014
CHILD AND ADULT CARE FOOD PROGRAM
OPERATIONAL MEMORANDUM #16**

TO: Child and Adult Care Food Program Institutions

FROM: Marla J. Moss, Director
Office of School Support Services

DATE: July 14, 2014

SUBJECT: New - Request for Special Dietary Needs Accommodations Form

This memorandum is to introduce a new form, the *Request for Special Dietary Needs Accommodations*. This new form combines two prior forms, the *Medical Exception Statement for Food Substitution* and the *Fluid Milk Substitution Form* into one form. This new form is being utilized by both the Child and Adult Care Food Program (CACFP) and the School Nutrition Programs (SNP).

The *Medical Exception Statement for Food Substitution* and the *Fluid Milk Substitution Form* were combined into one form to streamline documentation of special meal accommodations and to reduce the amount of paperwork to be completed by participants, parents or guardians of federal nutrition programs in the State of Michigan.

CACFP and SNP Institutions are to distribute this form to participants/parents/guardians when a special meal accommodation is requested. This form is to document a special meal accommodation when the participant has a disability or medical condition, which requires a special meal or accommodation, if the participant does not have a disability but requests a special meal or accommodation and/or if the participant does not have a disability but is requesting an accommodation for a fluid milk substitute that meets the USDA nutrient standards for non-dairy beverages.

This form can be found on the CACFP website, www.michigan.gov/cacfp, Forms and Instructions, Independent Centers and Sponsors of Centers, Parent Forms. It can also be found on the School Nutrition Website www.michigan.gov/schoolnutrition under Special Dietary Needs.

To see a list of non-dairy beverages that meet the USDA nutrient standards for non-dairy beverages at the time of publication, please see either website. Please note that MDE does not endorse any product listed and that manufacturer's product specifications may change at any time.

If you have any questions regarding this memorandum, please contact the Child and Adult Care Food Program at 517-373-7391.

[Request for Special Dietary Needs Accommodation Form](#)

**Michigan Department of Education
Office of School Support Services**



REQUEST FOR SPECIAL DIETARY NEEDS ACCOMMODATIONS

The information on this form should be updated as necessary to reflect the current needs of the participant.

1. School/Agency Name:		2. Site Name:		3. Site Telephone:	
4. Name of Participant/Student:				5. Participant Age:	
6. Name of Parent/Guardian:				7. Parent/Guardian Telephone:	
8. Check One: <input type="checkbox"/> Participant has a disability or a medical condition and <i>requires</i> a special meal or accommodation. (Refer to instructions on reverse side of this form.) Schools and agencies participating in federal nutrition programs must comply with requests for special meals and any adaptive equipment. A licensed physician currently managing the disability care of this participant/student must sign this form. <input type="checkbox"/> Participant <i>does not have a disability</i> , but is requesting a special meal or accommodation due to food intolerance(s) or other medical reasons. Food preferences are not an appropriate use of this form. Schools and agencies participating in federal nutrition programs are not required to make accommodations when there is not a documented disability but may make accommodations for reasonable requests at their discretion. A licensed physician, physician's assistant, registered dietitian, or nurse practitioner must sign this form. <input type="checkbox"/> Participant <i>does not have a disability</i> , but is requesting a special accommodation for a fluid milk substitute that meets the USDA nutrient standards for non-dairy beverages offered as milk substitutes. Granting the request of a non-dairy milk substitute is at the discretion of the facility. Product Name: _____ Meets Requirements? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure Reason for request: _____ Please skip to #15. A licensed physician, physician's assistant, registered dietitian, nurse practitioner, or parent/guardian must sign this form.					
9. Disability or medical condition requiring a special meal or accommodation:					
10. If participant has a disability, provide a brief description of participant's major life activity affected by the disability:					
11. Diet prescription and/or accommodation: (<i>describe in detail to ensure proper implementation-attach additional pages as needed</i>)					
12. Foods to be omitted and substitutions: (<i>list specific foods to be omitted and suggested substitutions - attach additional pages as needed</i>)					
Food(s) To Be Omitted:			Suggested Substitution(s):		
13. Indicate texture: <input type="checkbox"/> Regular <input type="checkbox"/> Chopped <input type="checkbox"/> Ground <input type="checkbox"/> Pureed					
14. Adaptive Equipment:					
15. Signature of Parent/Guardian:		16. Printed Name:		17. Date:	
18. Signature of Medical Authority:		19. Printed Name with Credentials:		20. Telephone:	21. Date:

REQUEST FOR SPECIAL DIETARY NEEDS ACCOMMODATIONS INSTRUCTIONS

1. **School/Agency Name:** Print the name of the school or agency that is providing the form to the parent.
2. **Site Name:** Print the name of the site where meals will be served (e.g., XYZ school, XYZ child care center, XYZ family day care home, etc.).
3. **Site Telephone:** The telephone number of site where meal will be served. See #2.
4. **Name of Participant/Student:** Print the name of the child or adult participant to whom the information pertains.
5. **Participant Age:** Print the age of the participant. For infants, please use Date of Birth.
6. **Name of Parent/Guardian:** Print the name of the person requesting the participant's medical statement.
7. **Parent/Guardian Telephone:** Print the telephone number of parent or guardian.
8. **Check One:** Check a box () to indicate whether participant has a disability, does not have a disability or does not have a disability but is requesting special accommodation for fluid milk substitution.
9. **Disability or medical condition requiring a special meal or accommodation:** Describe the medical condition that requires a special meal or accommodation (e.g., juvenile diabetes, allergy to peanuts, etc.).
10. **If participant has a disability, provide a brief description of participant's major life activity affected by the disability:** Describe how the physical or medical condition affects the participant. For example: "Allergy to peanuts causes a life-threatening reaction."
11. **Diet prescription and/or accommodation:** Describe a specific diet or accommodation that has been prescribed by a physician or describe diet modification requested for a non-disabling condition. For example: "All foods must be either in liquid or pureed form. Participant cannot consume any solid foods."
12. **Food(s) to be omitted and suggested substitution(s):** List specific foods that must be omitted. For example, "exclude fluid milk." List specific foods to include in the diet. For example, "Nutritionally equivalent non-dairy beverage."
13. **Indicate texture:** Check a box () to indicate the type of texture of food that is required. If the participant does not need any modification, check "Regular."
14. **Adaptive Equipment:** Describe specific equipment required to assist the participant with dining. Examples may include: sippy cup, large handled spoon, wheel-chair accessible furniture, etc.
15. **Signature of Parent/Guardian:** Signature of parent/guardian requesting the accommodation.
16. **Printed Name:** Print name of parent/guardian completing form.
17. **Date:** Date parent/guardian signed form.
18. **Signature of Medical Authority:** Signature of medical authority requesting the special meal or accommodation.
19. **Printed Name with Credentials:** Print name of medical authority, including credentials.
20. **Telephone:** Telephone number of medical authority.
21. **Date:** Date medical authority signed form.

The Americans with Disabilities Act Amendment Act defines a "disability," in part, as a physical or mental impairment that substantially limits a major life activity or major bodily function of an individual. (For additional information on the definition of disability, please refer to Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendments Act of 2008). Information regarding the ADA, which expanded the definition of disability, can be found at: <http://www.law.georgetown.edu/archiveada/documents/ComparisonofADAandADAAA.pdf>

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